UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

KAREN LaMANTIA,

Plaintiff,

v.

VOLUNTARY PLAN ADMINISTRATORS INC., et al.,

Defendants.

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NO. CIV. S-01-1933 LKK/GGH

O R D E R

Plaintiff, Karen Lamantia ("plaintiff"), filed this action against Hewlett-Packard Company Employee Benefits Organization pursuant to the Employee Retirement Income Security Act ("ERISA") to recover benefits provided under an employee income protection plan. This matter comes before the court on cross-motions for summary judgment. I decide the motions based on the papers and pleadings filed herein and after oral argument.

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I.

FACTUAL BACKGROUND[1]

A. THE PLAN

Plaintiff, who held a full-time position as Account Representative in Hewlett-Packard's Customer Support department, was a member of the Hewlett-Packard Company Employee Benefits Organization Income Protection Plan ("Plan"). The Plan was adopted by Hewlett-Packard Company ("HP") to provide its employees with income in the event of certain disabilities. HP sponsors the plan through the Hewlett-Packard Company Employee Benefits Organization ("the Organization"). The Plan is self-funded by HP, rather than insured through an insurance company, and is administered pursuant to the Administrative Services Contract it has with Voluntary Plan Administrators, Inc. ("VPA"), which acts as the claim administrator for the Plan.

For VPA to approve a claim for Plan benefits, a member must establish that he or she is "Totally Disabled" as defined under the Plan. Def's Ex. E at HP00354-00355. The requirements for Total Disability vary, depending upon whether the member seeks short or long term disability benefits. Where the member seeks short-term disability ("STD") benefits, Total Disability means that, "following the onset of injury or sickness, the member is continuously unable to perform each and every duty of his or her Usual Occupation." A member's Usual Occupation is defined as the normal work assigned to the member by HP. Def's Ex. E at

[1] Unless otherwise noted, these facts are undisputed.

HP00358. The Plan also provides that a member must be under the care of a licensed physician and be examined at a frequency consistent with the Member's condition. Def's Ex. E at HP00355. If a member qualifies, the member is entitled to up to a maximum of 39 weeks of STD benefits.

By contrast, after the initial 39 week period, where a member seeks long-term disability ("LTD") benefits, Total Disability means that, "the Member is continuously unable to perform any occupation for which he or she is or may become qualified by reason of his or her education, training or experience." Def's Ex. E at HP00355. Certain conditions are excluded under the Plan from consideration for LTD benefits. First, the Plan provides:

> Any condition diagnosed as, or without regard to its designation is equivalent to, (1) attention deficit disorder (ADD), or (2) chronic fatigue syndrome, Epstein-Barr Virus, or infectious mononucleosis shall be disregarded in determination of Total Disability . . . .

Def's Ex. E at HP00355. The Plan also provides:

> [I]n the case of a disability resulting from a nervous or mental disorder, the Member shall be considered Totally Disabled only if he or she is confined to a hospital or other licensed long-term care facility for the treatment of such disability or has been so confined for fourteen (14) or more consecutive days during the preceding three (3) months.

Def's Ex. E at HP00356. Under the Plan, an illness is considered a nervous or mental disorder if:

> 1. The illness has psychologic or behavioral manifestations or results in impairment of mental functioning due to any causes including, but not

> limited to, social, psychological, genetic, physical, chemical or biological; and
> 2. The illness has a primary diagnosis that either is listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised, or falls within diagnostic codes 290 through 319 in the International Classification of Diseases, 9th Revision.

Id.

The Plan's claims administrator, VPA, must make the determination of Total Disability on the basis of "objective medical evidence," which the Plan defines as "evidence establishing facts or conditions as perceived without distortion by personal feelings, prejudices or interpretations." Def's Ex. E at HP00355. It is the member seeking benefits who is "solely responsible for submitting the claim form and any other information or evidence on which the Member intends the Claims Administrator to consider in order to render a decision on the claim." Def's Ex. E at HP00375.

Where a claim for benefits is denied, the Plan provides that the member is permitted to appeal the denial by submitting a written request for review. Def's Ex. E at HP00377. With respect to an appeal of a denial of benefits, the Organization "is the named fiduciary which has the discretionary authority to act with respect to any appeal from a denial of benefits. The Organization's discretionary authority includes the authority to determine eligibility for benefits and to construe the terms of the Plan." Id.

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Upon appeal of a denial of benefits, the claims administrator must "give the claimant (or the claimant's representative) an opportunity to review pertinent documents . . . in preparing a request for review." Id. The Plan provides, however, that the claimant is "solely responsible for submitting a written request for review of the claim and any other information or evidence on which the Member intends the Claims Administrator to consider in order to render a decision on review." Def's Ex. E at HP00377. The claims administrator may require the claimant to seek additional information or evidence as it deems appropriate to its review. Id.

The Plan provides that, absent special circumstances, a request for review should be "act[ed] upon" "within sixty (60) days after the receipt thereof," and "[i]n no event shall the decision of the Claims Administrator be rendered more than one hundred twenty (120) days after it receives the request for review." Def's Ex. E at HP00378. The Plan further provides that a claimant should receive written notice of a denial of the appeal and the specific bases for denial. It also provides, however, that, absent written notice that additional time for review is required, "within sixty (60) days of the date his or her request for review is reached by the Claims Administrator, the claim shall be deemed to have been denied on review." Even where a claimant is given notice that additional time is required for review, the Plan provides that where the claimant "does not receive written notice of the Claims Administrator's

decision with respect to his or her claim within one hundred twenty (120) days after the date the Claims Administrator receives the request for review, the claim shall be deemed to have been denied." Def's Ex. E HP00379.

Should the claimant wish to file suit regarding the denial of benefits, the Plan provides that the claimant must first exhaust the so-called administrative remedies set forth in the Plan. Def's Ex. E at HP00379. The Plan also contains a time limitation for bringing suit. It provides that "[N]o action at law or equity shall be brought to recover benefits under the Plan unless the action is commenced within four (4) years after the occurrence of the loss for which the claim is made." Id. The Summary Plan Description provides plan members with information concerning the exhaustion requirement and the limitations for suit. It reads: "No legal action may be taken until all the claim review procedures have been completed. No legal action may be taken to gain benefits from the Plan after four years from when the disability occurred." Def's Ex. E at HP00441.

II.

PROCEDURAL BACKGROUND

A. PLAINTIFF'S BENEFITS CLAIM

On August 19, 1996, plaintiff filed her initial claim for STD benefits under the Plan. She described her disability as anemia, hysterectomy, and stress. In the Physician's Certification of Disability, her doctor explained that

plaintiff's primary diagnosis was iron deficiency and anemia, and listed "chronic immune deficiency fatigue syndrome" as a secondary diagnosis. Plaintiff was awarded short-term benefits.

On February 27, 1997, plaintiff filed a claim for long-term disability benefits in which she listed a number of symptoms including nausea, muscle and joint pain, stress, chronic bronchitis, headaches, anxiety, depression, and panic attacks. The VPA denied plaintiff's claim for LTD benefits by letter dated May 14, 1997. In the letter, Dee Goodenough, a VPA employee with the title "Disability Benefit Specialist," addressed the limitations on disability claims based on mental health issues and chronic fatigue syndrome. She then asserted that the objective medical records supported that plaintiff was being treated for chronic fatigue syndrome, fibromyalgia,[2]

[2] Fibromyalgia has been recognized in this Circuit as a physical rather than a mental disease. Jordan v. Northrop Grumman Corp. Welfare Benefit Plan, 370 F.3d 869 (9th Cir. 2004). In Jordan, the court held that:

> This syndrome . . has traditionally been used for an ill-defined, poorly understood set of symptoms, consisting of aching pain and stiffness in one or several parts of the body. As we have previously explained, fibromyalgia's cause or causes are unknown, there is no cure, and, of greatest importance to disability law, its symptoms are entirely subjective. There are no laboratory tests for the presence or severity of fibromyalgia. The 'consensus' construct of fibromyalgia identifies the syndrome as associated with generalized pain and multiple painful regions .... Sleep disturbance, fatigue, and stiffness are the central symptoms, though not all are present in all patients. The only symptom that discriminates between it and other syndromes and diseases is multiple tender spots, which we have said were eighteen fixed locations on the body that when pressed firmly cause the patient to flinch. The diagnosis is now based on patient reports of a

depression, and chronic bronchitis, but did not support a limitation in function due to these conditions. Goodenough concluded that, in her opinion, the objective medical evidence in the file did not support any limitation in function due to bronchitis. She also stated that, as to the diagnosis of fibromyalgia, the medical records contained no supporting data that plaintiff's symptoms were the result of an organic impairment. Goodenough noted that plaintiff had a right to request review, and informed plaintiff that she would receive a written decision within 120 days of the date of her request for review. Goodenough also noted that if plaintiff did not receive a written decision within 120 days, "the appeal can be considered denied." Def's Ex. E at HP00067.

In a letter dated June 10, 1997, plaintiff appealed the denial of benefits, alleging that she was disabled due to fibromyalgia, chronic fatigue syndrome, immune deficiency syndrome, pulmonary problems, and depression. She stated that she was appealing on the basis that her fibromyalgia, pulmonary problems, and immune deficiency syndrome were disabling. Def's Ex. E at HP00062-63.

> history of pain in five parts of the body, and patient reports of pain when at least 11 of 18 points cause pain when palpated by the examiner's thumb. Although . . . the syndrome [may not be] []either "progressive" []or "crippling," the symptoms can be worse at some times than others. Objective tests are administered to rule out other diseases, but do not establish the presence or absence of fibromyalgia.

Id. (omitting internal quotations and citations).

On July 1, 1997, copies of the Plan were sent to plaintiff's attorney, along with most of plaintiff's medical records. VPA informed plaintiff's counsel that any additional information plaintiff wished to submit should be submitted within 30 days. Def's Ex. E HP00005-6, 00061. On July 24, 1997, plaintiff's attorneys requested additional time to acquire additional medical documentation to support her appeal. VPA agreed to extend the appeal submission date another thirty days to September 3, 1997. VPA sent copies of additional medical reports to plaintiff's counsel on August 11, 1997, and gave plaintiff until September 8, 1997 to submit her information. On September 18, 1997, plaintiff's counsel sent VPA a copy of a report from Dr. Agresti dated September 16, 1997, and stated that an additional report would be forthcoming. The following day, in a telephone conversation with Lance Tomei of VPA, plaintiff's counsel stated that it might take another month to schedule plaintiff for a medical evaluation. On October 3, 1997, plaintiff's counsel sent a letter to Tomei purporting to "memorializ[e] our agreement that the appeal review . . . will not conclude until such time as Ms. LaMantia has obtained a report from an evaluator of her choice and submitted said report." Pl.'s Evidence in Oppo. to Def's Motion at 403. Plaintiff's counsel wrote that he hoped to obtain the report in two months.

Whether plaintiff's counsel continued seeking to communicate with VPA over the next three years is in dispute.

In any event, it appears that the dialogue resumed in August of 2000. At that time, VPA received a letter from plaintiff's current counsel asking for a response to materials that plaintiff's counsel had allegedly sent in 1999. VPA responded that they had not received the materials and asked for copies, along with an explanation as to why there had been a delay between October 1997 and 1999. There is no record of any explanation for the delay, but plaintiff's counsel did send copies of the missing materials.

It was another year before VPA sent a letter to plaintiff's counsel stating that her appeal was denied. Claims Manager, Janet Curry, asserted that plaintiff's medical file did not support a conclusion that plaintiff could not work on the basis of chronic bronchitis and fibromyalgia, but that the symptoms alleged are "those of depression, chronic fatigue syndrome, and Epstein Barr virus and in the absence of these symptoms, she could return to her job at Hewlett-Packard Company."

B. PLAINTIFF BRINGS THIS FEDERAL ACTION

Plaintiff filed suit on October 17, 2001. On December 20, 2002, this court determined that the VPA improperly denied plaintiff long term disability benefits. The defendant appealed and, on March 23, 2005, the Ninth Circuit reversed in part and remanded. See LaMantia v. Voluntary Plan Administrators, Inc., 401 F.3d 1114 (9th Cir. 2005). The Circuit court held that, in this case, the correct standard of review is that of abuse of discretion, instead of the de novo standard applied by this

court. Further, the Circuit explained that, subsequent to issuance of this court's decision, the "treating physician rule[3]," applied in this case, was rejected by the High Court and is no longer good law. See Black & Decker Disability Plan v. Nord, 538 U.S. 822(2003). Accordingly, this court now reviews the parties' summary judgment motions consistent with the Ninth Circuit's instructions.

III.

STANDARDS

A. SUMMARY JUDGMENT

The purpose of summary judgment "is to isolate and dispose of factually unsupported claims or defenses." Celotex v. Catrett, 477 U.S. 317, 323-24(1986). To obtain summary judgment, a party must demonstrate that no genuine issue of material fact exists for trial, and that based on the undisputed facts he is entitled to judgment as a matter of law. Id. at 322.

The moving party "bears the initial responsibility of informing the district court of the basis for its motion, and identifying those portions of 'the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any' which it believes demonstrate the absence of a genuine issue of material fact." Id. at 323. The

[3] Under that rule, the opinions of a claimant's treating physicians were given special deference and could be disregarded only for clear and convincing reasons based on substantial evidence in the record. See Regula v. Delta Family-Care Disability Survivorship Plan, 266 F.3d 1130 (9th Cir. 2001), vacated, 539 U.S. 901 (2003).

court must draw all justifiable inferences in favor of the non-moving party. Masson v. New Yorker Magazine, Inc., 501 U.S. 496, 520 (1991).

If the moving party meets its initial burden, then the non-moving party "must set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e). However, "[i]f a moving party fails to carry its initial burden of production, the non-moving party has no obligation to produce anything, even if the nonmoving party would have the ultimate burden of persuasion." Nissan Fire & Marine Ins. Co. v. Fritz Cos., 210 F.3d 1099, 1102-03 (9th Cir.2000).

B. REVIEW OF PLAN ADMINISTRATOR'S DECISION UNDER ERISA

A district court reviews an ERISA plan benefits denial "under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 115(1989). Where a plan does give the administrator such discretionary authority, courts review a claim denial under an abuse of discretion standard.[4] LaMantia v. Voluntary Plan Administrators,

[4] The Ninth Circuit has used the term "arbitrary and capricious" to describe this deferential standard of review. Taft v. Equitable Life Assur. Soc., 9 F.3d 1469(9th Cir. 1993)(citing Dytrt v. Mountain State Tel. & Tel. Co., 921 F.2d 889, 894 (9th Cir. 1990); Madden v. ITT Long Term Disability Plan, 914 F.2d 1279, 1284 (9th Cir. 1990), cert. denied, 498 U.S. 1087 (1991)). The Circuit has explained that, because the court "employed review in those cases consistent with the strictures of the abuse of discretion standard, however, [the] use of a different term was 'a distinction without a difference.'" Id. at n.2 (quoting Cox v. Mid-America Dairymen, Inc., 965 F.2d 569, 572 n.3 (8th Cir. 1992))

Inc., 401 F.3d 1114 (9th Cir. 2005). As the Ninth Circuit has already determined, "[t]he circumstances of this case fall into the . . . exception for when an abuse of discretion standard of review will apply."[5] Id. at 1123. Accordingly, this court may review only the evidence presented to the Plan trustees. Id. at 1471.[6]

In assessing whether a claim administrator abused its discretion, the court considers whether the claim denial was unreasonable. Clark v. Washington Teamsters Welfare Trust, 8 F.3d 1429, 1432 (9th Cir.1993). ERISA plan administrators abuse their discretion when they "construe provisions of the plan in a way that conflicts with the plain language of the plan." Eley v. Boeing Co., 945 F.2d 276, 278 (9th Cir.1991). An abuse of discretion will also be found if the administrator relies on

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(citing Block v. Pitney Bowes Inc., 952 F.2d 1450, 1454 (D.C. Cir. 1992)("The distinction, if any, between 'arbitrary and capricious review' and review for 'abuse of discretion' is subtle.")).

[5] The LaMantia panel explained that the Plan does in fact give VPA "'the discretionary power to construe the language of the Plan and make the decision on review,'" and that the VPA did actually exercise that discretion.

[6] The defendant argues that evidence subject to this court's review is limited to that before VPA pertaining to plaintiff's condition as of the end of the short-term disability ("STD") period when VPA made its decision on her claim for LTD benefits ("LTD decision date"). In other words, it maintains that the court may only review evidence before the VPA before May 14, 1997. However, the decision being challenged and reviewed here is the final decision made by the VPA after reviewing plaintiff's appeal of the May, 1997 denial. As the Ninth Circuit explained, defendant "never considered LaMantia's claim to be fully denied until August 24, 2001, when a final decision on the merits was rendered." LaMantia at 1119. That "final decision . . . analyz[ed] all the medical evidence VPA [received up to that date] and reaffirm[ed] its 1997 initial denial." Id. at 1123. Accordingly, the court will review all of the evidence before the VPA as of the date of the final decision.

clearly erroneous findings of fact in making benefit determinations, Taft v. Equitable Life Assur. Soc., 9 F.3d 1469, 1473 (9th Cir. 1993), or the decision is unsupported by substantial evidence. Johnson v. District 2 Marin Eng'rs. Beneficial Ass'n., 857 F.2d 514, 516 (9th Cir. 1988).

When the discretionary authority is granted to an administrator who is operating under a conflict of interest, however, that conflict must be considered in determining whether there is an abuse of discretion. Eley, 945 F.2d at 278-79. If a conflict of interest is found, the "decision will be entitled to some deference, but this deference will be lessened to the degree necessary to neutralize any untoward influence resulting from the conflict." Doe v. Group Hospitalization & Medical, 3 F.3d 80, 87 (4th Cir. 1993). The courts have been less that clear as to when a conflict actually arises and what the correspondent heightened standard should be. The Ninth Circuit has instructed generally that the deference should be lessened "when the administrator is not entirely impartial or objective, and may have a vested interest in denying benefits." Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 536 (9th Cir. 1990). The "lesser deference standard" should "only apply . . , however, if the . . . decision implicates a serious conflict between the interests of the employer and the beneficiaries." Oster v. Barco of California Employees' Retirement Plan, 869 F.2d 1215, 1217-18 (9th Cir. 1988); Jordan v. Northrop Grumman Corp. Welfare Benefit Plan, 370 F.3d 869, 875 (9th Cir.

2004)("the standard of review changes with the existence of a 'serious' conflict only"). A conflict of interest can be evidenced by a showing that the plan administrator acted in bad faith. Jung v. FMC Corp., 755 F.2d 708 (9th Cir. 1985).

IV.

ANALYSIS

A. HEIGHTENED STANDARD OF REVIEW

Before reaching the merits, I must address a threshold issue concerning the applicable standard of review. Plaintiff contends that the court should apply a modified abuse of discretion standard because the VPA allegedly operated under a conflict of interest.[7] I examine this contention below.

Plaintiff first asserts that a less deferential standard should apply because defendant acted in bad faith when it failed to render a timely decision of her appeal of the denial of long-term disability benefits. The Ninth Circuit has already addressed this issue and foreclosed this argument. The panel determined that the delays in making a final determination on plaintiff's appeal were not a result of defendant's bad faith because it was plaintiff "who sought an extension of time which

[7] The defendant asserts that the court need not examine whether a heightened abuse of discretion standard applies because the Ninth Circuit already made that determination. I cannot agree. There is nothing in the record suggesting that the Ninth Circuit considered whether a conflict of interest existed as to warrant a less deferential review or that the question was even before it. Rather, the scope of the Ninth Circuit's discussion of the standard of review was limited to explaining why the abuse of discretion and not a de novo standard applies. Accordingly, this court not only can, but must, resolve the question before going any further.

caused the deadline to file documents to occur beyond the deemed-denial date." LaMantia at 1123.

Plaintiff next argues that defendant acted in bad faith because the VPA arranged for her to be evaluated by more than one doctor. According to plaintiff, this demonstrates that the VPA "acted more as an advocate for denial, than a fair and impartial third party looking to make the right decision." This argument is unsupported by any legal authority and is less than convincing. Nothing in the record supports a finding that the independent medical examinations were impermissible.

Finally, plaintiff asserts that there was a conflict of interest because the Company, the Organization, the Plan and VPA are all agents of each other. Plaintiff attempts to show the Organization exercised complete control over the VPA and that the impartiality of the VPA is therefore questionable. The parties agree that the benefits are paid by the Organization out of a trust fund. Pl.'s SUF 5, 6. The VPA is a third-party claims administrator that receives and processes claims for benefits and computes claim payments. Id. at 14, 15. The Organization has discretionary authority with respect to any appeal from a denial of benefits to determine eligibility for benefits and to construe the terms of the plan. Pl.'s SUF 8. Here, plaintiff concedes that the final decision made on August 24, 2001, was made by Janet Curry, claims manager for VPA. Pl.'s Oppo. to Def.'s Mot. at 5.

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From what the court can tell, it appears that the premise of plaintiff's contention is that the defendant was self-interested in reducing the amount of benefits it was required to pay out. The Ninth Circuit has rejected this argument. In Oster v. Barco of California Employees' Retirement Plan, 869 F.2d 1215, 1217-18 (9th Cir. 1988), the court explained that, "[t]o some extent, a potential conflict of interest" inherently exists in these types of benefit plans because "[a]ny action that enhances the financial viability of the Plan tends to reduce the potential contributions of the company." According to the Oster panel, "[a] contrary conclusion would mean that we must always consider [administrators] of a defined benefit plan as subject to a conflict of interest, which we are unwilling to do." Id. at 1217-18. The Circuit affirmed this position in Jordan v. Northrop Grumman Corp. Welfare Benefit Plan, 370 F.3d 869 (9th Cir. 2004). There, the court stated that, where an "insurance policy is both issued and administered by the same party, in order to establish a 'serious' conflict of interest . . . 'the beneficiary has the burden to come forward with material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary.'" Id. at 875-76 (quoting Bendixen v. Standards Ins. Co., 185 F.3d 939, 943 (9th Cir. 1999)).

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Accordingly, plaintiff's contention that she "ha[d] a financial interest in getting the money, while the plan ha[d] a financial interest in keeping it, . . . cannot [alone] establish [a] conflict of interest in the administrator, because it would leave no cases in the class receiving deferential review . ." Id. at 876. Plaintiff fails to alert the court to other circumstances which may constitute the types of serious conflicts of interest recognized in this Circuit. See, e.g., Dytrt v. Mountain States Tel. & Tel. Co., 921 F.2d 889 (9th Cir. 1990). The court will therefore not modify the abuse of discretion standard.

B. DEFENDANT'S INITIAL DENIAL

The parties agree that plaintiff, as an eligible California employee, was entitled to receive state income disability benefits for a 52 week period beginning in August of 1996. See Cal. Un. Ins. Code §§ 2601 et seq. Plaintiff complains that VPA wrongfully evaluated her eligibility for long-term disability benefits as of May, 1997, at the end of the Plan's 39 week short-term disability period, instead of August 1997, at the end of the 52 week period. According to her, it was "serious error" for VPA to make a determination of total disability for the purposes of long term benefits after 39 weeks of receiving short term benefits, instead of 52 weeks, and that such error warrants reversal of its decision. Although plaintiff's argument is less than clear, she appears to contend that defendant was required to provide her with short-term disability benefits for the

entire 52-week period and was precluded from evaluating or instituting long-term disability benefits before that period. As I explain below, plaintiff's contention fails for various reasons.

First, plaintiff's contention that defendant violated state law when it evaluated her application for long-term disability benefits at the end of the 39-week period is unpersuasive and unsupported by any legal authority. The defendant maintains that state law requires only that the employer provide California employees with benefits for the minimum of 52 weeks, but that it does not restrict employers from meeting this requirement by paying long-terms benefits during that time. Specifically, defendant explains that, under state law, employers may elect to assume administration and payment of the additional California benefits through a voluntary plan, for a fee paid to the State, and that HP has elected such a voluntary plan, as described in Supplement C to the Plan. Supp. Curry Decl. ¶ 3. Defendant asserts that HP has elected to fund and administer the state disability benefits as a voluntary plan, and claims are processed by VPA in accordance with the state regulations and are paid through the HP payroll system at the rate set by the state. According to defendant, this simply means that HP's California employees who qualify for short-term disability benefits under the Plan are entitled to at least the amount of benefits payable under the California state disability plan, regardless of whether they meet the stricter definition of

Total Disability under the Plan for the period after the 39th week. Thus, if a California employee does not meet the definition for LTD benefits after the 39th week, his or her benefits continue but are limited to the weekly state benefit set out the California Unemployment Insurance Code. See Cal. Un. Ins. Code § 2655; Supp. Curry Decl. ¶4. Plaintiff does not dispute defendant's contentions. Further, she concedes that she was paid short-term disability benefits for the entire 52-week period.

In any event, plaintiff was in no way prejudiced by defendant's evaluation of her application at the end of the 39-week period rather than after 52 weeks. There is no indication that any new documents were available at the end of the 52 week period that were not available at the end of the 39 week period. Therefore, any procedural error committed by defendant was harmless, since waiting an additional 13 weeks to assess plaintiff's status would have been inconsequential.

More importantly, VPA's initial assessment has no bearing on the larger issue now before the court, that is, whether or not VPA's ultimate denial of benefits was an abuse of discretion. The final determination of her long-term application was not made until August of 2001, which included a review of plaintiff's medical reports from September 1997 to 1999. Accordingly, the medical reports reviewed by VPA were not limited to those dated before May 1997, as claimed by plaintiff.

C. FUNCTIONAL LIMITATION TO ESTABLISH TOTAL DISABILITY

I now examine defendant's contention that, notwithstanding the cause of plaintiff's disability, it reasonably found that she was not "functionally limited in any objectively measurable degree" such that she could be found disabled from performing any occupation consistent with her training and experience.

The Plan places the burden of proof in establishing "Total Disability" on the member. The Plan explicitly provides that the member is "solely responsible for submitting the claim form and any other information or evidence on which the Member intends the Claims Administrator to consider in order to render a decision on the claim." Plan § 7(b); Curry Decl. ¶ 9 and Ex. E, HP00375. Accordingly, plaintiff had to show that she was "continuously unable to perform any occupation for which he or she is or may become qualified by reason of his or her education, training or experience." Plan § 2(q)(ii); Curry Decl. ¶ 7 and Ex. E, HP00355. Defendant maintains that, even assuming that plaintiff's diagnoses of chronic bronchitis and fibromyalgia were correct, the medical records before it did not support plaintiff's contention that she was functionally limited from working. Accordingly, I review the record to determine the reasonableness of defendant's conclusion that there was no objective medical evidence to support a determination that plaintiff was functionally disabled from performing any job as defined by the Plan.

The record includes documentation from her treating physicians, Dr. Agresti and Dr. Herman, both of whom wrote letters in June of 1997 discussing her diagnoses of chronic respiratory infections and fibromyalgia. In her letter, Dr. Agresti stated that "due to the persistence of her symptoms she has been advised that she needs to be off work. Her treatment plan is for Intravenous gamma globin therapy, be off work until symptoms diminish, in order that she may be able to tolerate a work schedule." See Pl.'s Ex. 2 at 000103. Dr. Herman stated that "she remain off of work at this time until her symptoms are under control . . ." Pl.'s Ex. 6 at 000126.

On July 3, 1997, Dr. Agresti again reported that "LaMantia may not return to work . . . due to fibromylagia and immune deficiency syndrome." The report contains the additional comment that she "[c]annot return to any type of work even outside of Hewlett Packard." Pl.'s Tr. 105. Again in September of 1997, Dr. Agresti wrote a letter stating that plaintiff's "medical condition has affected her so that she has not been able to attain her goals and have debilitated her to the point that she cannot work." Pl.'s Ex. 15 at 402.[8]

According to the defendant, this documentation was insufficient to allow it to find that plaintiff was functionally

[8] Plaintiff also points to a report written by Dr. Agresti on August 23, 2002 concluding that "LaMantia is totally disabled from all forms of occupations for which she is reasonably qualified based on her education, training and experience, due to Chronic bronchitis, Fibromyalgia, and Chronic Immune Deficiency." Pl.'s Tr. 108h. This report is outside of the administrative record and cannot be considered by the court.

disabled from performing any job, as described by the Plan, because the doctor's statements related to her functional abilities were conclusory. Defendant maintains that these conclusions did not satisfy plaintiff's burden to produce "objective medical evidence" of "Total Disability," and it was prohibited, under the terms of the Plan, to treat these conclusory statements as objective medical evidence of Total Disability. In addition to its contention that the only evidence of her functional abilities consisted of conclusory statements, it also presents three additional grounds to support its ultimate decision. First, it asserts that VPA contacted Dr. Agresti to request specific information regarding plaintiff's functional limitations due to any disability, but that Dr. Agresti failed to respond. Defendant presents evidence that on November 27, 1996, it specifically requested that Dr. Agresti define plaintiff's capabilities and specific restrictions. The evidence reflects that VPA wrote to Dr. Agresti requesting that Dr. Agresti "please call . . . to discuss the importance of defining Karen LaMantia's capabilities to help her in returning to work." Curry Decl. ¶ 20 and Ex. E, HP00263 (emphasis added). This request included a copy of plaintiff's job description along with a form to complete defining her "specific restriction." Id., HP00264-00266. There is nothing in the record showing that Dr. Agresti ever replied to this request.

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Defendant further points to physician reports which disagree that plaintiff was disabled from doing any type of job which she is qualified or may be qualified for, and which, on the contrary, indicate the possibility of her ability to work. In a Physician's Status Questionnaire signed on December 18, 1996, Dr. Agresti vaguely indicated that plaintiff's physical restrictions are "activity as tolerated – rest." Curry Decl. ¶ 21 and Ex. E, HP00260. Dr. Agresti made an identical comment as to plaintiff's limitations on a March 3, 1997 note, id., HP00198, and again on April 7, 1997, answered the question about plaintiff's functional limitations and/or restrictions on activities of daily life with the following conclusion: "limited to level she can tolerate depending on her pain and level of fatigue." Id., HP00104.

Defendant also explains that, although Dr. Nagua, a UC Davis rheumatologist hired by VPA to do an Independent Medical Evaluation ("IME") in January 1997, noted that Ms. LaMantia was limited in her physical abilities, VPA chose to reject that statement because it was qualified and inconclusory. The record supports defendant's contention. Dr. Naguwa stated that "[t]hough the patient has had at least a 50% decrease in her usual ability to function, there is insufficient data as to the completeness of her evaluation to seek an organic cause for her symptoms." HP00233. Dr. Naguwa also concluded that Ms. LaMantia's "condition may be improved," and recommended a "more precise definition of her condition." Id.

Defendant also contends that it was reasonable for it to reject plaintiff's physicians' conclusory statements because the record included evidence bringing the diagnoses of chronic bronchitis and fibromyalgia, the conditions allegedly causing her physical limitations, into doubt. Dr. Neil Wood, a rheumatologist who performed an IME on July 17, 1997, opined that he did not believe that plaintiff had fibromyalgia as a clinical entity and ultimately concluded that the diagnosis of fibromyalgia was unwarranted. Curry Decl. ¶ 34 and Ex. E, HP00011; HP00047-HP00050. Further, regarding the diagnosis of chronic immune deficiency based on decreased levels of IGG and DHEA, Dr. Wood opined that the clinical significance of the "slight decrease in IGG" and "low S-DHEA" has never been completely established. Curry Decl. ¶ 2 and Ex. E, HP00048. Similarly, in a report plaintiff's counsel provided to VPA during the appeal of her claim, Dr. David Kneapler, a Board-certified internist and rheumatologist, stated that "[t]he role of her selective IG3 deficiency is still unclear, as, when that is problematic, it usually causes recurrent infections, and her clinical history has not been characterized by that." Curry Decl. ¶ 2 and Ex. E., HP00019-HP00023. According to defendant, these reports reasonably cast doubt on plaintiff's conditions, which consequently cast doubt on her functional limitations due to these conditions.

The Ninth Circuit has recently reviewed questions similar to the ones the court faces here. In Jordan v. Northrop Grumman

Corp. Welfare Benefit Plan, 370 F.3d 869 (9th Cir. 2004), the plaintiff challenged the denial of long-term disability benefits based on fibromyalgia. The defendant there denied the application for benefits on the grounds that plaintiff did not present objective evidence that the condition of fibromyalgia rendered her "completely unable to engage in any occupation or employment for which [she was] or [would] become qualified." Id. at 872. The evidence submitted by the plaintiff there included a treating physician's statement that "patient can't function even sedentary work at present because of flare up of her fibromyalgia and intensity of pains." Id. at 873. Another of plaintiff's physicians submitted that "under her current state of affairs, she is medically disabled from her job as a secretary." Id. at 874.

In reviewing plaintiff's appeal of the district court's disposition in favor of the defendant, the Ninth Circuit first reiterated that courts "cannot substitute [their] judgment for the administrator's. [They] can set aside the administrator's discretionary determination only when it is arbitrary and capricious." Id. at 875. It explained that "a decision grounded on any reasonable basis is not arbitrary or capricious, and that in order to be subject to reversal, an administrator's factual findings that a claimant is not totally disabled must be clearly erroneous. Id. (internal quotations and citations omitted).

The Ninth Circuit determined that the denial of the plaintiff's benefits was not unreasonable. First, it concluded

that the evidence submitted by her physicians regarding her physical work limitations were "nothing but their *ipse dixit* to substantiate the claim." Id. at 877. Although these doctors' reports stated that she was unable to work due to her medical condition, they never "explain[ed] why." Id. at 874. The court gave great weight to the fact that the defendant requested from plaintiff's physicians objective evidence to support their conclusory statements and that they failed to comply with this request. The court explained that "the failure of an employee's physician to respond to inquiries by the plan administrator undermine[s] evidence in the petitioner's favor." Id. at 878. Accordingly, the court was "bound to treat [plaintiff's] treating physicians' opinions that she was disabled by her fibromyalgia as undermined, which is to say less reliable or unreliable." Id. The court then evaluated the record consisting of: (1) plaintiff's physicians' conclusory statements, which did not explain why or for how long plaintiff was unable to work, (2) the physicians' failure to respond to defendant's specific request as the functional limitations, which undermined their reliability, and (3) evidence from defendant's independent physicians stating that plaintiff was not physically limited from all work. It then held that it could not conclude that the defendant had acted unreasonably in denying plaintiff long-term disability benefits.

Defendant contends that Jordan should guide this court's decision as to its finding that plaintiff was functionally

limited from all employment. I must agree. As in Jordan, plaintiff's physicians' statements concluded that her condition precluded her from working, but never explained what objective medical evidence supported those conclusions.[9] Similarly, defendant made a specific request to Dr. Agresti to provide it with the specific information that was missing, and Dr. Agresti failed to respond. Following Jordan, it was reasonable for defendant to render Dr. Agresti's conclusory statements less reliable. Finally, defendant also had before it medical evidence casting the diagnoses of the alleged debilitating conditions into question. Finally, the terms of the Plan made it clear that it was plaintiff's burden to produce objective medical evidence of a Total Disability. As in Jordan, given the method of analysis mandated, this court cannot conclude that it was unreasonable for defendant to deny her application for LTD benefits on the basis that she failed to prove that she was completely unable to work at any job for which she was or could become qualified for. Therefore, this court cannot disturb defendant's conclusion and replace it with its own judgment,

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[9] Plaintiff contends that defendant erred by not considering her continuing receipt of Social Security benefits for fibromyalgia and chronic bronchitis because they are compelling evidence that she was entitled to LTD benefits. When a court finds substantial evidence in the administrator's decision lacking, the court may weigh a Social Security award in plaintiff's favor. Madden v. ITT LTD Plan, 914 F.2d 1279 (9th Cir. 1990); Pierce v. American Waterworks Co., 683 F.Supp. 996, 1000 (W.D. Pa. 1988).

Here, however, given Dr. Kneapler's report, the court cannot find that there was no substantial evidence to support the administrator's decision. Thus, the prerequisite for weighing the Social Security award was lacking.

because under current doctrine, VPA was within its discretion to deny the claim. See also Bolling v. Eli Lilly & Co., 990 F.2d 1028, 1029-30 (8th Cir. 1993) ("The [administrator] did not abuse its discretion merely because there was evidence before it that would have supported an opposite decision."); Eley, 945 F.2d at 279 (no abuse of discretion to deny benefits despite expert evidence showing that a certain procedure was diagnostic and therefore was covered by the plan); Sandoval v. Aetna Life and Cas. Ins. Co., 967 F.2d 377 (10th Cir. 1992)(no abuse of discretion to deny benefits despite report by one doctor concluding that plaintiff was totally disabled).

V.

CONCLUSION

Defendant's motion for summary judgment is GRANTED and plaintiff's motion for summary judgment is DENIED. If reopened on remand from the Circuit, the Clerk is directed to close the case.

IT IS SO ORDERED.

DATED: August 18, 2005.

/s/Lawrence K. Karlton
LAWRENCE K. KARLTON
SENIOR JUDGE
UNITED STATES DISTRICT COURT